

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02745

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sex	5. Color of eyes	6.(a) Single, married, widowed, or divorced
Male		Widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Mar. 24, 1946

(month) (day) (year)

Cemetery or crematory

Location Bloomsburg - Columbia Co. Penna.

18. Funeral director

Address J. Willis Wells
Chestertown, Maryland19. Mar. 22, 1946
(Date rec'd by registrar)Clara S. Barnes
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 21, 1946 NR

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

March 7, 1946, to March 21, 1946,
and that I last saw him alive on March 20, 1946.

Immediate cause of death

Heart attack

Due to

Bronchitis

Due to

Bronchitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Heart

Date of op.

Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

Cause of death

23. SIGNATURE

M. D. or brother

Address Chestertown, Maryland Date signed Mar. 22, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

02746

CERTIFICATE OF DEATH

Reg. Dist. No. 204

1. PLACE OF DEATH: Hart
County Chestertown

City or town R.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life
Hospital, institution, or street address where death occurred:

How long in hospital or institution? none

3. (a) FULL NAME Isaac Bowers

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Grace Washington

7. Birth date of deceased (mo., day, yr.) Jan 25 1863

8. AGE: 85 Years 3 Months 6 Days If less than one day .hrs. .min.

9. Birthplace Hart Co Md
(Town, county, and state) James L Brown

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Dout Brown

13. Birthplace Saint Louis

14. Maiden name Becky Bowers

15. Birthplace Saint Louis

16. Informant Brook Hart Stephen

Address Chestertown R.D. MD

17. Burial Buried Date thereof May 6 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broad Neck Cemetery

Location Broad Neck

18. Funeral director Admiry Fleury

Address Chestertown MD

19. Date rec'd by registrar May 4 1946 Registrar J. W. Smith
(Date rec'd by registrar) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Hart

City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 3 1946

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 2nd until his death and that I last saw him alive on Mar 3rd

and the cause of death was old age

and the duration several days

Due to renal disease

Due to arterio sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. 1946

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of 1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Fallen Injured at work? No

23. SIGNATURE John H. Miller M. D. or other MD

Address Chestertown MD Date signed 3/4/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02747

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

Kent
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

301 Queen St.

How long in hospital or institution?

3. (a) FULL NAME

Faith Ann Brown

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced
female colored single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)

June 19, 1945

8. AGE: Years Months Days If less than one day
9 9 hrs. min.9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER
12. Name..... Benjamin Brown
13. Birthplace..... Kent Co. MarylandMOTHER
14. Maiden name..... Mary Redding
15. Birthplace..... Baltimore City Md.

16. Informant..... Mrs. Mary R. Brown (mother)

Address..... 301 Queen St. Chestertown, Md.

17. Burial..... Date thereof..... Mar. 29, 1946
(Burial, cremation, or removal. Which?)Cemetery or crematory..... Cemetery.....
Location..... Chestertown, Md.

18. Funeral director..... J. Willis Wells

Address..... Chestertown, Md.

19. MAR. 28 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Kent

City or town..... SAME
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
(Meller)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Mar. 28 1946, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 20 1946, to Mar. 28 1946

and that I last saw her alive on Mar. 27 1946

Immediate cause of death..... Congenital
cardiac lesion
(Mutual)

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

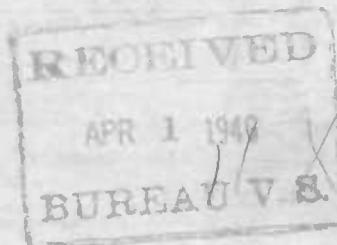
23. SIGNATURE..... H. G. Simmers

M. D. or other

Address..... Chestertown Date signed 3-28-46

Don Slay

281



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-8

02756

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:

County Kent

City or town Betterton, Kent Co. Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Franklin Davis

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Harriett Casy Davis

Deceased 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1872

8. AGE: Years 73 Months 6 Days 8 If less than one day hrs. min.

9. Birthplace Rock Hall, Kent County, Md. (Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

12. Name George W. Davis

13. Birthplace Rock Hall, Md.

14. Maiden name Rosa Harrison

15. Birthplace Rock Hall, Maryland

16. Informant Frances Davis Davis - Daughter

Address Betterton, Maryland

17. Burial Date thereof 3-3-46
(Burial, cremation, or removal, When?) (month) (day) (year)

Cemetery or mortuary Wesley Chapel

Location Rock Hall, (rural), Md.

18. Funeral director J. Willis Weeks

Address Chestertown, Maryland

19. March 1, 1946 J. H. Clark
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County KENT

City or town ROCK HALL Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1946, at 5:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1946, to Feb. 28, 1946, and that I last saw him alive on Feb. 28, 1946.

Immediate cause of death Cerebral Hemorrhage DURATION

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

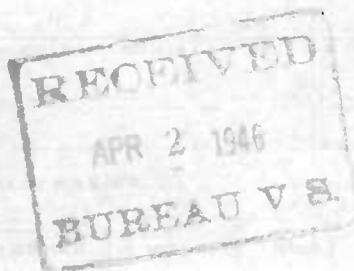
Means of injury

Injured at work?

23. SIGNATURE

James E. Dedman, M.D.
M.D. or other

Address Betterton, Md. Date signed March 1, 1946



UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:	

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	APR 3 1946	1 week ago
Run over by street car		1 week ago
Peritonitis		3 days ago

Other contributory causes of importance:	

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BFD*

02749

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH:

County.....*Tent*City or town.....*Chesapeake*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*56 yrs.*

Hospital, Institution, or street address where death occurred:

121 E. High St.

How long in hospital or Institution?

3. (a) FULL NAME

George Davis Sofland

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*M**W**Widowed*

6.(b) Name of husband or wife

(late) Georgia E Sofland

7. Birth date of deceased (mo., day, yr.)

Feb. 19 1857

(b) If alive, give age

years

8. AGE:

Years Months Days If less than one day

*89**1**2*

hrs.

min.

9. Birthplace

Cecil County Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

*Hardware**Unknown*

12. Name

13. Birthplace

14. Maiden name

Unknown

15. Birthplace

16. Informant

Mr. Julian Jones

Address

Chesapeake, Maryland.

17. Burial

Date thereof.....*3/33/46*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Bethel Cemetery

Location

Chesapeake City Cecil Co. Md.

18. Funeral director

Naomi V. Williams

Address

*Chesapeake, Maryland.*19. Mar. 23 1946
(Date rec'd by registrar)Clara S. Barnes
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland*County.....*Tent*City or town.....*Chesapeake*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....*121 E. High*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*March 21*1946, at *2:00 A.M.*I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 6* to *March 21*, 1946, and that I last saw him alive on *March 20*, 1946.

Immediate cause of death.....

Cardio Renal Disease

DURATION

2

Due to.....

*Arterio Sclerosis**2*

Due to.....

*Unknown**2*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

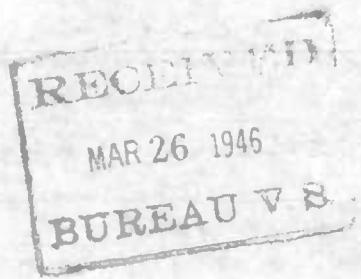
*None**2*

Date of op.....

*None**2*

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

02750

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County.....

Kent
Chesapeake

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

50 yrs.

Hospital, institution, or street address where death occurred:

105 Maple Ave

How long in hospital or institution?.....

3. (a) FULL NAME

Herman Biddle Massey

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m

w

Widowed

6. (b) Name of husband or wife.....

(late) Manah Ford Massey

7. Birth date of deceased (mo., day, yr.)

Feb. 8, 1871

6.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

75

1

15

hrs.

min.

9. Birthplace.....

Georgetown, Kent Co. Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

Farmer

MOTHER

FATHER

12. Name.....

C. H. B. Massey

13. Birthplace.....

Massey, Md.

14. Maiden name.....

Amanda Oklahoma

15. Birthplace.....

Cecilton, Md.

16. Informant.....

Mrs. A. H. Massey (Son)

Address

448 Faby Blvd. Shaford Conn.

17. Burial.....

Date thereof.....

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or

St. Clements Cemetery

Location.....

Massey, Kent Co. Md.

18. Funeral director.....

Maurine V. Williams

Address

Georgetown, Maryland

19. Date rec'd by registrar.....

March 25, 1946

(Data rec'd by registrar)

Clara L. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Kent

City or town.....

County.....

Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

105 Maple Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 23

1946

at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 26, 1946, to March 23, 1946,

and that I last saw him alive on March 23, 1946.

Immediate cause of death.....

Influenza

DURATION

18 days

Due to.....

Influenza

DURATION

17 hrs.

Due to.....

Heart attack

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

None

Date of op.

Autopsy results.....

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide.....

No

Date of

Where did injury occur?

Home

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

Traced Jones' bed

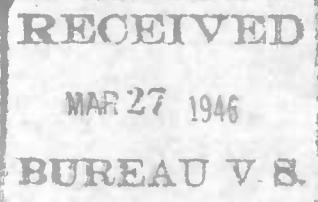
Baltimore bed 3/24/46

Address.....

M. D. or other

Date signed

Chesterton bed 3/24/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

02751

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County.....

Kent

City or town.....

Rural -

Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Wilhelmina Henrietta Middleton

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife

Edward B. Middleton

7. Birth date of deceased (mo., day, yr.)

August 18, 1886

6.(c) If alive, give age years

8. AGE:

Years Months Days If less than one day
59 6 18 hrs. min.

9. Birthplace

Rock Hall, Kent, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name Frederick Staths

MOTHER

13. Birthplace Germany

14. Maiden name

Mary Kisnick

15. Birthplace

Germany

16. Informant

Mrs. Willard H. Middleton

Address

Chestertown, Md

Burial

Date thereof Mar. 9. 1946

(month) (day) (year)

Cemetery or crematory

Chester Cem.

Location

Chestertown, Md.

18. Funeral director

J. Willis Wells

Address

Chestertown, Md.

19. March 6, 1946
(Date rec'd by registrar)Clara L. Barnes
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6-

1946, at 11⁵⁰/A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 18, 1945, to March 19, 1946,

and that I last saw her alive on 3-4 1946

Immediate cause of death

Generalized metastatic carcinoma 1 year

Due to carcinoma of rt breast

2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

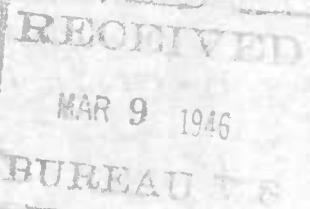
Means of injury

Injured at work?

23. SIGNATURE

Al. Dick, leet
M. D. or other

Address Chestertown, Md Date signed 3-6-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8-02

02752

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Kent

City or town near Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? left live 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Anne Island Robertson Hammer

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced

Female white widow

6. (b) Name of husband or wife Frank Hammer

7. Birth date of deceased (mo., day, yr.) December 1st - 1894

8. AGE: Years Months Days If less than one day
11 3 16 hrs. min.9. Birthplace Philadelphia Pa
(Town, county, and state)

10. Usual occupation House wif

11. Industry or business

12. Name William Heron Robertson

13. Birthplace England

14. Maiden name Emily Rose

15. Birthplace England

16. Informant Mrs Emily Hammer

Address Chestertown RR. Md

17. Burial Date thereof Mar. 20, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory IU Cemetery

Location nr. Worton - Kent Co. Maryland

18. Funeral director J. Willis Wells

Address Chestertown, Maryland

19. March 19, 1946
(Date rec'd by registrar)Clara S. Barnes
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town near Chestertown Md
(If outside city or town limits, write RURAL and give nearest town)Street No. Chestertown RR. Md
(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1946 at 3:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1946 to Mar. 12, 1946

and that I last saw h. alive on Mar. 12, 1946

Immediate cause of death

Feverish accident

Duration 4 hours

Due to advanced heart disease

5:30 A.M.

Due to

Other conditions other activities

1935

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank W. Smith

M. D. or other

Address Chestertown

Date signed 3/7/46

RECEIVED

MAR 21 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 110

02753

CERTIFICATE OF DEATH

Reg. Dist. No. 21020

1. PLACE OF DEATH:

County.....

City or town..... Chester-town, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

84 years

Hospital, institution, or street address where death occurred:

Kent County Queen Anne Hospital

5 days

How long in hospital or institution?.....

3. (a) FULL NAME

Lucy G. Robertson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Widowed

8. (b) Name of husband or wife.....

Wm. H. Robertson

7. Birth date of

deceased (mo., day, yr.)

Aug 16, 1862

(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

83

6

14

hrs.

min.

9. Birthplace.....

Chester-town, Kent, Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

FATHER

12. Name..... John H. Greenwood

MOTHER

13. Birthplace..... Maryland

Maiden name.....

14. Lucy R. Burgess

Birthplace.....

15. Rock Hall, Md.

16. Informant.....

Hospital Records

Address.....

Chester-town, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Mar. 5, 1946

(month) (day) (year)

Cemetery or crematory.....

Chester Cem.

Location.....

Chester-town, Maryland

18. Funeral director.....

J. Willis Wells

Address.....

Chester-town, Md.

19. Date rec'd by registrar.....

March 4, 1946

(Date rec'd by registrar)

Class S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Chester-town (If outside city or town limits, write RURAL and give nearest town)

Street No..... Queen

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 2 1946 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 26 1946 to March 2 1946

and that I last saw her alive on March 2 1946

Immediate cause of death.....

Carbon monoxide poisoning

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of 2-26-46

Where did injury occur?..... Chester-town Kent Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Home

Means of Injury..... Unlighted gas burner

Injured at work?

23. SIGNATURE.....

A.C. Stick

M. D. or other

Address..... Chester-town

Date signed..... 3-2-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

02754

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:

County Kent
 City or town Millington, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Emma West Skinner4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife James E. Skinner7. Birth date of deceased (mo., day, yr.) Sept. 2, 1867 6. (c) If alive, give age _____ years8. AGE: Years 78 Months 6 Days 26 It less than one day hrs. min.9. Birthplace Delaware (Town, county, and state) Housewark10. Usual occupation Housework

11. Industry or business

12. Name John Frank13. Birthplace Germany14. Maiden name Barbara Alcott15. Birthplace Del.16. Informant Mrs. Leo. GaleAddress Millington, Md.17. Burial Date thereof March 31, 1946
(Burial, cremation, or removal? When?) (month) (day) (year)Cemetery or crematory Church HillLocation Church Hill, Maryland18. Funeral director Edward T. EvansAddress Millington, Md.19. Date rec'd by registrar March 30, 1946 Edward T. Evans
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Millington
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1946 at 1 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1946 to March 28 1946 and that I last saw her alive on March 27 1946.Immediate cause of death Initial Hernia
Cir. large rectal
Cir. intestinal intusDue to Initial Hernia Cir. large rectal Cir. intestinal intus Duration Several days

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

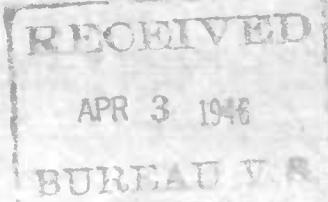
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Mary T. Evans M. D. or other _____Address Millington, Md. Date signed 3/31/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1302

02755

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH:

County Chester County

City or town Chestertown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

JAN 1864

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

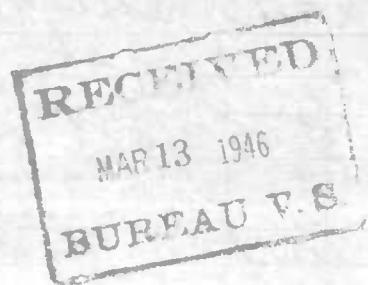
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

CERTIFICATE OF DEATH

02757

203

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Kent

City or town.....

Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

—

3. (a) FULL NAME

William Gentry White

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

col.

widowed

B.(b) Name of husband or wife.....

Eunice White

7. Birth date of deceased (mo., day, yr.)

not known

6. (c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day

about 82

hrs. min.

9. Birthplace.....

Rock Hall, Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

William Gentry White

FATHER

12. Name.....

Kent Co., Md.

MOTHER

13. Birthplace.....

Priscilla

14. Maiden name.....

Kent Co., Md.

15. Birthplace.....

Kent Co., Md.

16. Informant.....

Mrs. Rachel Long

Address

Rock Hall, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... (month) (day) (year)

March 16 1946

Cemetery or crematory.....

Sharktown

Location.....

Kent Co. Md.

18. Funeral director.....

Asbury Henry

Address

Lafayetteville, Md.

19.

March 16 1946

March 16

1946

Elwood Burgess

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Kent

City or town.....

Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Sharktown

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 16

1946, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 20 1946, to March 17 1946,

and that I last saw him alive on 3 - 10 1946.

Immediate cause of death.....

old age

chron. Endo. degeneration

Due to..... arteriosclerosis

DURATION

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Albert A. Burgard

M. D. or other

Address.....

Rock Hall, Md.

Date signed 3/15/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

102758

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 19 yrs.

Hospital, Institution, or street address where death occurred:..... 228 Hunt Club

How long in hospital or institution?

3. (a) FULL NAME

William Fisher Wilson

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Phoebe May Wilson

7. Birth date of deceased (mo., day, yr.)

June 15 1875

6.(c) If alive, give age

63

years

8. AGE:

Years
70Months
8Days
23

If less than one day

hrs.

min.

9. Birthplace.....

Wilton Delaware

(Town, county, and state)

10. Usual occupation

Bookkeeper

11. Industry or business

Purlys Furniture Co. Inc.

MOTHER FATHER

12. Name.....

John C. Wilson

13. Birthplace.....

Wilton Delaware

14. Maiden name.....

Mary Anna Carpenter

15. Birthplace.....

Wilton Delaware

16. Informant.....

Mrs. O. May Wilson (wife)

Address

Chesapeake Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

3/12/46

(month)

(day)

(year)

Cemetery or crematory.....

St. Paul

Location.....

New Fairlee Kmt Co. Md.

18. Funeral director.....

Fanning & William

Address.....

Chesapeake Maryland

March 12, 1946

Clara S. Barnes

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborns or infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Chesapeake (If outside city or town limits, write RURAL and give nearest town)

Street No..... 228 Kent Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

212-03-8132

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Mar 12

1946 at 11:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 10 1946

1946

1946

and that I last saw him alive on March 9 1946

1946

Immediate cause of death.....

Pulmonary

Disease

Due to.....

Cardiac

Due to.....

Disease

Other conditions.....

Hypertension

years

(Include pregnancy within 8 months of death)

Major findings or operations.....

None

Date of op.

Autopsy results.....

No

Date of...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

No

Date of...

Where did injury occur?.....

home

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Draed F. New Jr.

M.D. or other

Address..... Chesterton Rd Date signed..... March 12, 1946

39-14

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MAY 1942 EDITION
GSA GEN. REG. NO. 27, 2000

RECEIVED IN THE LIBRARY OF CONGRESS
MARCH 18 1946

